COMMONWEALTH OF KENTUCKY

907 KAR 1:070
Incorporation by Reference

MAP 1 O-H, Kentucky Medicaid Program
Homecare Waiver Services
January 2000 Revision

MAP-350, Long Term Care Facilities and Home and
Community Based Program Certification Form
January 2000 Revision

MAP 4 1 OOH, Homecare Waiver Services,
Provider Information and Services
January 2000 Revision

MAP-9, Commonwealth of Kentucky, Cabinet for Human Resources,
Kentucky Medicaid Program,
Prior Authorization for Health Services
December 1995 Revision

DSS 891-1,2, The Plan of Care
July 1996 Revision

The State of Kentucky, Aging Services
Client Enrollment
January 2000 Revision

MAP-24, Commonwealth of Kentucky,
Cabinet for Families and Children,
Department for Community Based Services
January 2000 Revision

Cabinet for Health Services
Department for Medicaid Services
Division of Long Term Care
275 East Main Street 6W-B
Frankfort, Kentucky 4062 1

MAP 10-H (Rev. l-2000)

KENTUCKY MEDICAID PROGRAM
Homecare Waiver Services

TO:

AGENCY: _____

ADDRESS: _____

_____ PHONE: _____

PHYSICIAN'S RECOMMENDATION

I recommend the Homecare Waiver Services Program for:

CLIENT:

_____

ADDRESS: _____

_____ PHONE: _____

SOCIAL SECURITY# _____ MAID # _____

DIAGNOSIS(ES) _____

_____

I understand that the Homecare Waiver Services Program includes the following services, provided as needed: assessment / care planning, reassessment, case management, personal care, homemaker, attendant care, and environmental accessibility adaptations.

I certify that if Homecare Waiver Services were not available, nursing facility placement shall be appropriate for this individual in the near future.

PHYSICIAN'S NAME: _____ UPIN# _____

ADDRESS: _____

_____ PHONE: _____

_____

SIGNATURE DATE

LONG TERM CARE FACILITIES AND HOME AND COMMUNITY BASED PROGRAM CERTIFICATION FORM

I. ESTATE RECOVERY

Pursuant to the Omnibus Budget Reconciliation Act (OBRA) 'of 1993, states are required to recover from an individual's estate the amount of Medicaid benefits paid on the individual's behalf during a period of institutionalization or during a period when an individual is receiving community based services as an alternative to institutionalization.

In compliance with Section 1917 (b) of the Social Security Act, estate recovery will apply to nursing facility long term care services (NF, NF/BI, ICF/MR/DD), home and community based services that are an alternative to long term care facility services and related hospital and prescription drug services.

Recovery will only be made from an estate if there is no surviving spouse, or children under age 21, or children of any age who are blind or disabled.

I certify that I have read and understand the above information.

Signature Date

II. HOME AND COMMUNITY BASED WAIVER SERVICES .FOR THE AGED AND DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, MODEL WAIVER II, BRAIN INJURY WAIVER

A. HCBS - This is to certify that l/legal representative have been informed of the HCBS waiver for the aged and disabled. Consideration for the HCBS program as an alternative to NF placement is requested _____; is not requested _____

Signature Date

B. This is to certify that l/legal representative have been informed of the home and community based waiver program for people with mental retardation/ developmental disabilities. Consideration for the waiver program as an alternative to ICF/MR/DD is requested _____; is not requested _____

Signature Date

C. MODEL WAIVER II - This is to certify that l/legal representative have been informed of the Model Waiver II program. Consideration for the Model Waiver II program as an alternative to NF placement is requested _____; is not requested _____

Signature Date

D. BRAIN INJURY (BI) WAIVER - This is to certify that I/legal representative have been informed of the BI Waiver Program. Consideration for the BI Waiver Program as an alternative to NF or NF/BI placement is requested _____; is not requested _____

_____ _____
Signature Date

III. FREEDOM OF CHOICE OF PROVIDER

I understand that under the waiver programs, I may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services.

_____ _____
Signature Date

IV. RESOURCE ASSESSMENT CERTIFICATION

This is to certify that l/legal representative have been informed of the availability, without cost, of resource assessments to assist with financial planning' provided by the Department for Community Based Services.

_____ _____
Signature Date

V. RECIPIENT INFORMATION

Medicaid Recipients Name: _____

Address of Recipient: _____

_____

Phone: _____

Medicaid Number: _____

Responsible Party/Legal Representative: _____

Address: _____

_____

Phone: _____

_____ _____ _____ _____

Signature and Title of Person Assisting with Completion of Form:

_____

Agency/Facility: _____

Address: _____

MAP-41 OOH (Rev. 01/2000)

HOMECARE WAIVER SERVICES
PROVIDER INFORMATION AND SERVICES

PROVIDER NUMBER: _____

AGENCY NAME: _____

AGENCY ADDRESS: _____
STREET OR P.O. BOX

_____
CITY, STATE, ZIP CODE

FROM THE FOLLOWING LIST, PLEASE CHECK EACH SERVICE FOR WHICH YOU WILL BE SUBMITTING CLAIMS:

1. _____ Case Management
(If this item is checked, this provider can charge for no other services, but may bill for #4)

2. _____ Homemaker

3. _____ Personal Care

4. _____ Environmental Accessibility Adaptations

By signing below I, _____ *certify*
Authorized Representative
that *this* **agency is** *capable of and* **agrees** *to comply with the conditions for participation established in the Homecare Services Waiver and regulation 907 KAR L-070. In addition, I certify* **that** *all* **staff shall** *meet* **all** *training requirements prior to the provision of services.*

_____ _____
SIGNATURE OF AUTHORIZED REPRESENTATIVE /TITLE DATE

9 (REV 12/95)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
KENTUCKY MEDICAID PROGRAM
PRIOR AUTHORIZATION FOR HEALTH-SERVICES

1. Med. Assist. I.D. No. (Ten Digits)	2. Recipient Last Name:	3. First Name:	4. M.I.
5a. Provider Number (Eight Digits)	6a. Provider Name, Address, and Phone Number		7. Co. # of Recipient Residence:
5b. Provider Number (Eight Digits)	6b. Provider Name, Address, and Phone Number		8. Date of Delivery (if already delivered)
9. Primary Diagnosis:			11. Date of Birth - - MM DD YYYY
10. Secondary Diagnosis:			

Signature of Provider: Date:

Caution: Order for you to receive payment. the recipient must be eligible on the date of service.
Check The Medicaid Card.

12. Line No.	13. Procedure/ Supply Description	14. Procedure Supply Code	15. Units of Service	16. Usual and Customary Charges	17. Medicaid Action A =Approved D=Disapproved	18. Approved Amount'
01.						
02.						
03.						
04.						
05.						
06.						

19. HCB and Model Waiver Providers enter, Approximate Total Monthly Charge:
$_____

DO NOT WRITE BELOW THIS LINE

20. Reason For Denial:

21.. Other Comments:

22. Prior Authorization Number:	23. Approval Dates:	24. Type of Service Authorized:
Mailroom Use:	From:	40___ DME 41 -MODEL WAIVER 45___ EPSDT/SPECIAL SERVICE 46___ HOME HEALTH 52___ H.C.B. 52 & 53 ___H.C.B & A.D.C 72___DENTAL ___OTHER
	Through:	
*Not used by H.C.B Waiver/Model Waiver		

Signature of Medicaid/Prior Authorization Respresentative:

Date:

Please refer to your billing instructions for the appropriate address.

PLAN OF CARE

Client _____ Initial Date of Plan of Care _____ Estimated Duration _____

Date Reassessment Due _____

Continuation of Plan of Care Date _____

Identified Problem or ed (Describe in .unctional terms)	Goals	Services	Provider Formal/Informal Units/time funding source
Physical: (health: utrition; ADLs: IADLS)	___ Enhance/or maintain client in current living arrangement ___ Establish/maintain personal hygiene ___ Enhance or/maintain highest level of functioning ___ Other _____	PERSONAL CARE ___ Bath (sponge, tub) ___ Nails ___ Bed making ___ Hair/shampoo ___ Mouth Care ___ Teeth/Dentures ___ Transfer patients to chair. ___ Assist with walking ___ Assist with dressing ___ Assist with toileting ___ Shave ___ Exercise ___ Other	___ Units of PC ___ x weekly Day _____ Funding _____
			___ Units of PC ___ x weekly Day _____ Funding _____
		___ ESCORT	___ Units of escort ___ x weekly Day _____ Funding _____
Physical aides/ environment: equipment/ household)	___ Establish/enhance/maintain clients nutritional status ___ Establish/enhance/maintain -- clients independence ___ Establish/enhance or maintain a clean and safe environment ___ Other _____	NUTRITION Teaching ___ Home Delivered Meals ___ Frozen Meals ___ Meal Preparation ___ Congregate Meals ___ Other _____ HOME HEALTH AIDE ___ B/P ___ Exercises ___ Skin Care ___ Dsg. ___ Diabetic routine ___ Foley cath. care ___ Appliances (Artificial limbs) ___ Other HOMEMAKER ___ Laundry ___ Shoppin ___ Sweep/Mop/Dust ___ Bedroom ___ Bathroom ___ Living ___ Kitchen ___ Dishes ___ Teaching ___ CHORE ___ HOMEREPAIR	___ Units of meals ___ x weekly Day _____ Funding _____ ___ Units of meals ___ x weekly Day _____ Funding _____ ___ Units of HHA ___ x weekly Day _____ Funding _____ ___ Units of HM ___ x weekly Day _____ Funding _____ ___ Units of HM ___ x weekly Day _____ Funding _____ ___ Units of Chore or Home Repair ___ x weekly Day _____ Funding _____

Identified Problem or Need [Describe)	Goals	Services	Provider Formal/Informal Units/time/ funding source
Social: mental/emotional)	___ Enhance/maintain highest level of functioning ___ Client to be safe and supported ___ Enhanced quality of life of the client ___ Enhanced quality of life of the caregiver Other _____ Other _____	**SOCIAL SERVICES** Referral ___ Telephone Reassurance Friendly Visiting ___ Legal Assistance Transportation Volunteer opportunities Senior activites Other	___ Units of _____ x weekly Day _____ Funding _____
		RESPITE Adult Day Center/ Alzheimer's Respite OR In-Home Respite ___ Reality Orientation ___ Recreational activities ___ Individuals/groups Socialization ___ Exercise/gait training ___ Education ___ Other Other	___ Units ofADC/Alz. Respite ___ x weekly Day _____ Funding _____ ___ Units of In-Home Respite ___ x weekly Day _____ Funding _____
Economic (income/lack of resources)	___ Establish/enhance or maintain client's ability to support self Other _____ Other _____	**BENEFITS** ___ Assistance in applying for benefits Guardianship/ conservator ___ Payee Money Management Teaching Benefits Counseling Other	___ Units of _____ ___ x weekly Day _____ Funding _____ ___ Units of _____ ___ x weekly Day _____ Funding _____
Other:	Other _____ Other _____		___ Units of _____ ___ x weekly Day _____ Funding _____ ___ Units of _____ ___ x weekly Day _____ Funding _____

"I have reviewed and agreed to the care plan. I have read and had explained to me the Quality Assurance procedure and have received a copy of the agreement."

Client _____, _____ Clients initials

Case Manager _____, Date _____

Adult Day Center Director _____, Date _____ (Adult Day Director should use different color of ink when completing Adult Day Services if completed on different date.) 7/96

1. Social Security # ☐☐☐☐☐☐☐☐☐

2. Date of Referral ___/___/___ MM DD YY

3. Date of Intake ___/___/___ MM DD YY

ate of Initial Assessment ___/___/___ MM DD YY

State of Kentucky
Aging Services
Client Enrollment

5. Priority # ____

6. Case Type ____ A, B, C, D, E, F

7. Worker Initial ____

8. ADD # ____

9. Provider # ____

10. Initial Program
- ☐ Title III
- ☐ Homecare
- ☐ Adult Day
- ☐ LTCM
- ☐ PCAP
- ☐ SSBG
- ☐ Other (Specify)

12. Medicare # ☐☐☐☐☐☐☐☐☐☐

13. Medicaid # ☐☐☐☐☐☐☐☐☐☐

14. Client Name (Last, First, Middle)

15. Phone #

16. Address (Street and Number)

17. Date of Birth ___/___/___ MM DD YY

11. Status
- ☐ Initial Enrollment Title III
- ☐ Enrollment Update Title III
- ☐ Re-enrollment - Title III
- ☐ Service Update
- ☐ Client Closure
- ☐ Initial Assessment
- ☐ Reassessment

18. City and State

19. Zip

20. County Code (Residence) ___ 3 digits

21. Title III - Under 60 as:
- ☐ 01. Spouse
- ☐ 02. Disabled
- ☐ 03. Staff
- ☐ 04. Volunteer
- ☐ 05. Guest

22. Area of Residence
- ☐ 01. Urban
- ☐ 02. Rural

23. Sex
- ☐ 01. Female
- ☐ 02. Male

24. Written Communication

Reading ☐ Yes ☐ No

Writing ☐ Yes ☐ No

25. Language
- ☐ 01. English
- ☐ 02. Spanish
- ☐ 03. Other/Unknown (Specify) ____

26. Citizenship
- ☐ 01. U.S.
- ☐ 02. Other (Specify) ____

27. Race
- 01. Asian/Pacific Island.
- 02. Am. Indian/Alaskan Origin
- ☐ 03. African American
- ☐ 04. Hispanic
- ☐ 05. Non-Minority
- ☐ 06. Not Reported

28. Marital Status
- ☐ 01. Never Married
- ☐ 02. Separated
- ☐ 03. Widowed
- ☐ 04. Divorced
- ☐ 05. Married
- ☐ 06. Not Reported

29. Household Composition
- ☐ 01. Lives Alone
- ☐ 02. With Spouse
- ☐ 03. With Children
- ☐ 04. With Relatives
- ☐ 05. With Non-Relatives
- ☐ 06. Not Reported

in Household

in Family

30. Title III- Annual Household Income (Optional)

(Greatest Economic Need automatically calculated below)

31. Homecare - Family Income
- ☐ 01. 0,000 - 3,000
- ☐ 02. 3,001 - 4,000
- ☐ 03. 4,001 - 5,000
- ☐ 04. 5,001 - 6,000
- ☐ 05. 6,001 - 7,000
- ☐ 06. 7,001 - 8,000
- ☐ 07. 8,001 - 9,000
- ☐ 08. 9,001 - 10,000
- ☐ 09. 10,001 - 12,000
- ☐ 10. 12,001 - 15,000
- ☐ 11. 15,001 - 18,000
- ☐ 12. 18,001 - 21,000
- ☐ 13. 21,001 - Above
- ☐ 14. Not Reported

32. Enrollment/Entitlements
- ☐ 01. Medicare ☐ Part A ☐ Part B
- ☐ 02. Medicaid
- ☐ 03. Medicare Supplement
- ☐ 04. Private Health Ins.
- ☐ 05. Health Related
- ☐ 06. Food Stamps
- ☐ 07. SSI
- ☐ 08. Veterans Benefits
- ☐ 09. Social Security
- ☐ 10. Retirement
- ☐ 11. None
- ☐ 12. Other (Specify) ____

33. Greatest Economic Need

☐ Yes ☐ No

34. Homecare Referral Source
- ☐ 01. Family
- ☐ 02. Physician
- ☐ 03. Hospitals
- ☐ 04. Alternate Care Facility
- ☐ 05. Home Health
- ☐ 06. Health Department
- ☐ 07. State Agency
- ☐ 08. Title III
- ☐ 09. Friends/Neighbors
- ☐ 10. Self
- ☐ 11. Homecare
- ☐ 12. Churches
- ☐ 13. Housing Managers
- ☐ 14. Other (Specify) ____

35. Please check services the participant may receive
- ☐ 01. *Adult Day/Adult Day Health
- ☐ 02. Advocacy/Representation
- ☐ 03. Assessment
- ☐ 04. *Case Management
- ☐ 05 * Chore Service
- ☐ 06. Counseling
- ☐ 07. Education/Training
- ☐ 08. Employment
- ☐ 09. Friendly Visiting
- 10. Health Promotion
- 11. Home Health Aide
- ☐ 12. Home Repair
- ☐ 13. *Homemaker
- ☐ 14. Information and Assistance
- ☐ 15. Legal Assistance
- ☐ 16. Meals - Congregate
- ☐ 17. *Meals - Home Delivered
- ☐ 18. Nutrition Counseling
- ☐ 19. Nutrition Education
- ☐ 20. Outreach/Client Finding
- ☐ 21. *Personal Care
- ☐ 22. Recreation
- ☐ 23. Respite
- ☐ 24. Telephoning
- ☐ 25. Transportation
- ☐ 26. Assisted Transportation (Escort)

Diet
- ☐ Regular
- ☐ Special (Specify) ____

*For items with asterisk, must complete ADL and IADL Section - six services for Title III.
Complete Nutritional Risk Assessment for Items 4, 16, 17, and 18 for Title III.

Client Name

36. Age Verification

- ☐ 01. Birth Certificate
- ☐ 02. Driver's License
- ☐ 03. School Record
- ☐ 04. Passport
- ☐ 05. U.S. Census Records
- ☐ 06. Employment Identification Card
- ☐ 07. Military/Veteran's Identification Card
- ☐ 08. Notorized Affidavit
- ☐ 09. Wedding or Divorce Decree
- ☐ 10. Social Security-Medicare Card (Category M certifies 65 or older)
- ☐ 11. Other- Describe _____

37. Nutritional Risk (Check all that apply)

	Points
☐ 0. None	0
☐ 01. I have an illness or condition that made me change the kind and/or amount of food I eat.	2
☐ 02. I eat fewer than 2 meals per day.	3
☐ 03. I eat few fruits or vegetables, or milk products.	2
☐ 04. I have 3 or more drinks of beer, liquor or wine almost every day.	2
☐ 05. I have tooth or mouth problems that make it hard for me to eat.	2
☐ 06. I don't always have enough money to buy the food I need.	4
☐ 07. I eat alone most of the time.	1
☐ 08. I take 3 or more different prescribed or over-the-counter drugs a day.	1
☐ 09. Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
☐ 10. I am not always physically able to shop, cook and/or feed self.	2
Total Points - -	

Score 6+ = High Nutritional Risk

8. Client's Physician _____ Phone No. _____

Preferred Hospital _____ Phone No. _____

Pharmacy _____ Phone No. _____

Emergency Contact _____ Phone No. _____

Emergency Contact Address _____

Do you have an Advance Directive: ___ Yes ___ No Describe _____

Location of Document _____

/ Legal Guardian / Power of Attorney (Describe) Effective Date Phone No.

9. Caregiver's Name _____ Phone No. _____

Caregiver's Address _____

Spouse's Name _____ Phone No. _____

Spouse's Address _____

Children: Name (Additional space on back) Address Phone No.

40. Directions to Home:

Statement of Confidentiality

The information recorded on this form is required for the statistical and reporting requirements for State and Community Programs under the Older Americans Act of 1965, as amended [Public Law 89731], and is not to be used for any other purpose in any form which could identify the individual without the individual's knowledge of the specific use and the individual's specific authorization for such use.

41. Closure Information & Closure Date

Closure Reason ____ ___/___/___ MM DD YY

- ☐ 00- Ineligible
- ☐ 01- Died
- ☐ 02- Moved
- ☐ 03- To Personal Care/Family
- ☐ 04- To Nursing Facility
- ☐ 05- Condition Improved
- ☐ 06- Client Request
- ☐ 07- Services not needed
- ☐ 08- Transferred to Title III
- ☐ 08a- Transferred to Homecare
- ☐ 09- Transferred to Day Care
- ☐ 10- Transferred to Another Agency/Prog.
- ☐ 11- Other (Specify) _____

☐ Reassessment

ADL/IADL ASSESSMENT/REASSESS.

Client Name

Respondent Name

Title III Need Circle Y or N

DEGREE OF ASSISTANCE NEEDED

ADLs		NONE	MINOR	MUCH PHYS.	COMPL. ASSIST.	NEEDS MET BY (NAME OF FAMILY/FRIEND/OR AGENCY)	NEEDS UNMET	TOTALLY MET	PART. MET	FRE-QUENCY
FF[illegible]LF	Y N									
TRANSFER	Y N									
TOILETING	Y N									
BATHING/ GROOMING	Y N									
DRESSING	Y N									
WALKING	Y N									

BEDBOUND Yes ____ No ____ CHAIRBOUND Yes N o WHEELCHAIR MOBILITY Yes ____ No ____

Title III Need Circle Y or N

DEGREE OF ASSISTANCE NEEDED

IADLs		NONE	MINOR	MUCH PHYS.	COMPL. ASSIST.	NEEDS MET BY (NAME OF FAMILY/FRIEND/OR AGENCY)	NEEDS UNMET	TOTALLY MET	PART. MET	FRE-QUENCY
MEAL PREPARATION	Y N									
SH[illegible]NG/ ER S	Y N									
LIGHT HOUSE WORK Dishes/ Dusting	Y N									
HEAVY HOUSEWORK Vac./Mopping	Y N									
PAY BILLS/ HANDLE MONEY	Y N									
USE TELEPHONE	Y N									
MEDICATION MANAGE-MENT	Y N									
LAUNDRY	Y N									
TRANSPORTA-TION ABILITY	Y N									

Comments: ____

Sect. P.

1/00 Edition

(For Additional Space Write On Back)

_____ Assessment

Client Name: _____

Respondent: _____

I. PHYSICAL HEALTH (Self Reported)

Overall Health _____ Excellent - - _____ Fair _____ Poor

1. Please indicate health problems experienced during the past 12 months by checking the block if client reports problems.

__ Anemia (low blood)
__ Arthritis/Rheumatism
__ Back Problems
__ Cancer/Leukemia
__ Circulation Problems
__ Cirrhosis
__ Constipation
__ Diabetes (Sugar)
__ Foot or Nail Problem
__ Gout
__ Heart Problems
__ High Blood Pressure
__ Injuries from fall/accident
__ Jaundice
__ Lung Problems
__ Osteoporosis (bone loss)
__ Paralysis
__ Parkinson's Dii (Palsy)
__ Prostate Enlargement
__ Recent Surgery
__ Shingles
__ Stroke
__ Urinary Tract Disorder
__ Vertigo (Dizziness)
__ Tb
__ Hepatitis
__ MRSA
__ Other (Specify) _____

2. Medical Conditions or Diagnoses: _____

3. Do you receive any of the following treatments or therzipies? Check all that apply.

a. __ Inhalation Rx
b. __ Oxygen
c. __ Suctioning
d. __ I.V. fluids
e. __ Tube feedings
f. __ Aseptic dressing
g. __ Lesion irrigation
h. __ Insulin therapy
i. __ Decubitus care
j. __ Sp skin care
k. __ Sp foot care
l. __ Catheter Irrigation
m. __ Ostomy care
n. __ Bowel-bladder rehabilitation
o. __ I.V. medicines
p. __ P.T.
q. __ O.T.
r. __ S.T.
s. __ A&b.-Trans. training
t. __ Exercise
u. __ Blood tranfusions
v. __ Other (Specify) _____

Providers' _____

4. Weight _____ Height _____

5. INCONTINENT Yes__ No__ BOWEL,, BLADDER__
OSTOMY _____ URINARY CATHETER _____

6. Do you smoke, dip or chew tobacco? _____

Skin Condition: __ Soft __ Dry __ Flakey __ Intact
__ Broken __ Reddened __ Rash

Totes on Health Conditions _____

Client Name:_____

I. PHYSICAL HEALTH (Continued)

Medications
(prescribed and over the *counter)*

Medicine	Dosage	Frequency-	Purpose	Doctor

dedication allergies _____

Alcohol and Drug Assessment

Following is a list of questions. The questions refer to your experiences over the last two years. The questions concern alcohol, prescription and other drug use. In these questions, alcohol refers to beverages such as wine, beer, whiskey; prescription drugs refers to medications prescribed by a doctors; over-the-counter medications means medications you can purchase without prescription; other drugs refers to illegal drugs. There are no right or wrong answers.

	YES	NO
. . Do you drink alcohol?	-	-
How often? _____		
What do you drink? _____		
. Do you use other drugs?	____	____
How often? _____		
What drugs? _____		

NOTES TO ASSESSOR: If the response to any of the items 1-2 is yes, proceed to the following set of questions. (If all responses to the above questions are no, please end this part of the interview.)

Relate the following questions to the substances which the client answered positively to in the above questions "1-2'. For example, if a client only responded to "yes" to drinking, and "no" to prescription and other drugs, then Question #3 would be read like this: Has your use of alcohol caused you a prol ' I ?

/00 Edition

Client Name: _____

II. PHYSICAL HEALTH (Continued)

	YES	NO
Has your use of alcohol, prescription drugs or other drugs caused you a problem?		
a. What type of problem do you have? _____		
4. Have you had any problems related to alcohol, prescription drugs or other drug use (e.g., liver disease, ever had blackouts or memory losses)?	___	___
5. Have you felt you should cut down on your drinking, prescription drugs or other drug use?	___	___
Has anyone (e.g., family member, friend, doctor) expressed concern that you used too much alcohol, prescription drugs or other drugs?	___	___
6. Have you used prescription medication without a prescription or more than was prescribed for you?	___	___
7. Is a referral for treatment or counseling needed?	___	___

8. How often do you see a doctor? _____
   Date of your last visit: _____ Purpose: _____
9. How often do you see a dentist? _____
   Date of your last visit: _____ Purpose: _____
   Do you wear dentures? Do they fit well? _____
   Do you have any dental problems? _____
10. Number of times institutionalized in the past6 months? (Where, why, how long)_____
11. Hospital/Emergency or Nursing Home _____
12. Are you on a waiting list for nursing home placement? ___Yes ___No

Nutrition

13. Would you say your appetite is: Excellent ___ Fair Poor
14. Do you require a diet modification? Yes No_____
    Da& physician's order last written? _____
    DIET MODIFICATION: __ Diabetic __ Fat Restricted __ Sodium Restricted __ Mechanical Soft ___ Other
15. How many glasses of liquid/fluid do you drink a day?_____
16. Has your physician prescribed any supplements? Vitamin/Mineral _____ Liquid _____
17. Are there foods you do not eat for religious reasons? _____
18. Do you have any known food allergies? If yes, explain
19. Is there any diet related information not previously questioned which should be induded? _____

Client Name: _____

SECTION III. ASSISTIVE DEVICES, SENSORY IMPAIRMENT AND COMMUNICATIONS

Comments :

PHYSICAL SUPPORT EQUIPMENT	Has	Uses	Needs
BED PAN			
BEDSIDE COMMODE			
ELEVATED TOILET SEAT			
TUB SEAT			
GRAB BARS			
CANE/CRUTCHES			
WALKER			
HOSPITAL BED			
LIFT CHAIR			
RAMP			
WHEELCHAIR			
PROSTHESIS			

SENSORY IMPAIRMENT:

VISION (with glasses if used)
- Adequate
- 2. Difficulty seeing print
- 3. Difficulty seeing objects
- 4. No useful vision
- 5. Not determined

ABILITY TO TASTE/SMELL
- 1; No Complaints
- 2 Reduced
- 3. Greatly Reduced
- 4. Absent

COMMUNICATION
- 1. Communicates needs/can beunderstood
- 2. Communicates need+ with difficulty/can be understood
- 3. Communicates needs with Sign language/gestures
- 4. Inappropriate content
- 5. Unable/does not communicate

If client uses/ has glasses-lenses:
When did you last see an eye doctor? _____
Renewed prescription for glasses? _____

HEARING (with hearing aid if used)
- 1. Adequate
- 2 Hearing difficulty at level of conversation
- 3. Hears loud sounds only
- 4. No useful hearing
- 5. Not determined

TOUCH.
- 1. Numbness or tingling in extremities
- 2 Unusually sensitive or or. intolerant to heat or cold

If client has hearing aid:
Whendidyoulasthaveaheatingtest? _____ RESULTS: _____

Is specialized evaluation needed for Impairment? _____

Comments: _____

Client Name _____

SECTION IV. PHYSICAL ENVIRONMENT.

Lives in: House- Apartment__ Other___ Amount of rent: _____
Client Owns- Rents(Subsidy)___ Other- . utilities: _____
Landlord: Name: _____
Address: _____
_____
Telephone: _____

Comments:

Check each category	Yes	No	Needs Repair
Sound building			
Sound furnishings			
Running water/(hot/cold)			
Adequate heating/cooling			
Tub/shower/commode (accessible and useable))			
Stove/microwave			
Refrigerator			
Freezer space			
Telephone (accessible and useable)			
TV/radio			
Washer/dryer			
Adequate space .			
Adequate lighting			
Adequate locks			
Neighborhood safe/secure			
Insect/Rodent problem			
Free of fire/safety/health hazards			
CO-Detector; Smoke Detectors			
Physical Barriers: stairs, narrow doorways			

Is client satisfied with present living arrangements? Yes ___ No ___
Does client plan to move? Yes ___ No ___
Plans _____
_____
Does client have pets? Yes___ No___ If yes, what kind? _____
Indoors _____
Outdoors _____
Comments _____
_____
_____

Client Name _____

SECTION V. FORMAL/INFORMAL RESOURCES

If you have a caregiver, how has your illness or disability affected the caregiver?

_____

_____

_____

_____

_____

SUPPORT SYSTEMS

Informal:

Name/Relationship	Address	Phone #

Formal:

Agency/Worker	Address	Phone #

POTENTIAL SYSTEMS

Name/Relationship	Address	Phone #

Client Name _____

SECTION V. (Continued) .

ACTIVITIES:

Hobbies/special interests
(In-home/out-of-home) _____

If no longer active with hobby, how long ago did client stop activity and why?

Participation at Senior' Center or Adult Day Center: _____

Former Occupation: _____

VOLUNTEER ACTIVITIES
Present: _____

Past: _____

Would you like an opportunity to volunteer in some capacity? _____

FAMILY INTERACTION: _____

RELIGIOUS AFFILIATION: _____
Attends Services: _____
Has In-Home Visits from Clergy or Congregation: _____

Listen To: Radio/TV Services: _____

Client's Name _____

E C T I O N V L MENTAL/EMOTIONAL STATUS .

the client has responded to the request for information for this assessment -- beginning with the intake ar as responded'appropriately and accurately, the assessor can go to the -"need help at night" ies... Enter N/A if the assessor does not complete the Mental Status Questionnaire and initial.

N/A _____ **Case Manager/Assessor Initials** _____

Mental Status Questionnaire

	CORRECT	ERROR
. Where are you now? What place is this?	_____	_____
What is the name of this place?	_____	_____
. Where is it located(address)?	_____	_____
. What is the date today? Day? (Score correct if within three days)	_____	_____
. Month?	_____	_____
. Year?	_____	_____
. How old are you?	_____	_____
. When were you born? Month?	_____	_____
. Year of birth?	_____	_____
. Who is president of the United States?	_____	_____
. Who was president before him?	_____	_____

you need help at night, how would you obtain it? _____

_____

_____

_____

Mental Health Screening

enext questions are mainly about how you have been doing in the lust six months.

	Yes	No
Have you had a lack of interest in most activities, and/or had low or sad moods?	___	___
Have you had brief, sudden attacks of shortness or breath, rapid heart beat, shaking or fearfulness? (If answered yes, . disregard if related to medical diagnosis.)		
Do you hear or see things other people do not seem to'notice?	___	___
Do you think someone is reading or controlling your thoughts?	___	___
Do you think anyone is especially against you?	___	___
Have you had severe nightmares?	___	___
Have you any thoughts about harming yourself?	___	___
Do you want to strike someone or destroy property when you get angry?	___	___
Hav vou received counsel.@ treatment for personal problems or em nal stress in the past 12 months?	___	___

Client's Name _____

SECTION VI. (Continued)

If yes, for what reason _____

Physician/ Agency providing treatment: _____

Would you be willing to accept assistance to receive treatment? _____

Describe any behavior problems identified by client or observed by Case Manager and how it effects client's functioning.

List recent major changes or crises that may be affecting client:

Comments:

Client's Name _____

SECTION VII. SUMMARY AND JUDGEMENT

Specialized evaluation/consultation necessary (describe):

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, 4062 l-000 1

DEPARTMENT FOR MEDICAID SERVICES
"An Equal Opportunity Employer M/F/D"

MEMORANDUM

TO: Local Office
Department for Community Based Services
Cabinet for Families & Children

FROM: _____
(Facility/Waiver Agency)

SUBJECT: _____
(Recipient Name) (Social Security/Medicaid Number)

_____
(Previous Address)

_____
(Responsible Relative's Name &Address)

This is to notify you that the above-referenced recipient

☐ was admitted to this facility/waiver agency _____ (Date)
is in Title _____ (XVIII or XIX) Payment Status, and was placed in a

☐ NF bed ☐ ICF/MR/DD bed ☐ MH bed

☐ Home & Community Based Service ☐ SCL Waiver Service and/or

☐ was discharged from this facility/waiver agency on _____ (Date)
and went to _____
(Home Address/Name &Address of New Facility/Waiver Agency)
and/or expired on _____ (Date)

☐ was re-instated to Home & Community Based or SCL waiver services within 60 days of the NF admission. _____
(Date Re-Instated)

For Home & Community Based waiver Clients on/y – last date service was provided _____,
(Date)

_____
(Signature)

MAP-24 (Rev. 01/2000)

EDUCATION